Research Article

An assessment of the functioning of the Village Health Sanitation and Nutrition Committee in the rural areas of Kamrup district, Assam

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Abstract

Background: The Village Health Sanitation and Nutrition Committee (VHSNC) is a first step toward decentralized planning and community empowerment approach

Objective: To assess the constitution of the VHSNCs, to assess the activities undertaken by them, and to assess the funding and utilization status of the VHSNCs.

Materials and Methods: Study design—Community-based cross-sectional study. Study place—Three blocks of Kamrup district viz, Boko-Bongaon, Hajo, and Sualkuchi. Study period—July 1 to October 31, 2015. Study population—The functionaries of VHSNCs present during visit and the records maintained. Sample size—Total 78 VHSNCs were assessed in this study. Sample collection technique—Out of the total 12 blocks, 3 blocks were selected. Sub-centers (50%) under these three blocks selected and two villages from each SC selected. All the 78 VHSNCs operating in these villages were included in this study. Data collection tool—Predesigned and pretested schedule containing both open- and closed-ended questions. Primary data were collected by interview method and secondary data obtained from various records.

Results: 55.12% VHSNCs had 11 or more members. Panchayati Raj Institution (PRI) member, Auxiliary Nurse Midwife (ANM), Accredited Social Health Activist (ASHA), Anganwadi Worker (AWW), and Medical officer were members in all of the committees. Only 16.67% of the VHSNCs conducted 10–12 meetings in 1 year. 16.67% VHSNCs had maintained and updated the untied fund register. Formation of new committee and new members (96.15%), ASHA's incentive (94.87%), and Anganwadi Center (AWC) repairing (88.76%) were commonly discussed topics in monthly meetings. A majority of 67.93% VHSNCs utilized more than 90% of the funds allotted to them.

Conclusion: It was observed that although VHSNCs have been constituted in all of the revenue villages in the study area, there are several lacunae in their organization.

KEY WORDS: Village Health Sanitation and Nutrition Committee (VHSNC), Panchayati Raj Institution (PRI) member, Auxiliary Nurse Midwife (ANM), Accredited Social Health Activist (ASHA), Anganwadi Worker (AWW), Anganwadi Center (AWC)

Introduction

Gandhi advocated that India lives in her villages and that India has no future worth the name unless these villages play their proper part in the life of the country.[1] Village sanitation and hygiene, village diet and health, medical relief, and basic education are some of the primary means by which, in Gandhiji's opinion, the goal of all-round village development can be attained. Involvement of people at the grassroot level is the most important means of bringing about socioeconomic development. The report of Study Group on "Health for All—an alternate Strategy" commissioned by ICSSR and ICMR (1980) under the chairmanship of Dr. V. Ramalingaswami indicated that most of the health problems of a majority of India's population were amenable to being solved at the primary health care level through community participation and ownership.[2] Rural health care services suffer from a shortage in public sector infrastructure, which is not only in terms of physical infrastructure but also human resource, measured

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even against the minimal norms prescribed by the government.[3,4] The two most important issues that emerge with regard to rural health infrastructure in the country are lack of access and poor quality of service. To address these issues, the National Rural Health Mission (NRHM) was launched by the Government of India (GOI) in April 2005. The NRHM places significant focus on supporting community participation to promote decentralized governance of systems of planning and delivery, at least at the district level. The district provides an opportunity for interface between policy and implementation of health programs at the community level, in addition to being a composite unit of the health system with a clearly defined administrative and geographical area, including the subcenter, the primary health center, the community health center, and the district hospital. Under NRHM (now NHM), the upgradation of the health facilities to improve quality of care requires the development and functioning of proper management structure, for example, Village Health Sanitation and Nutrition Committee (VHSNC) at the village level and Rogi Kalyan Samitis (RKS) at the institution level.

One of the key elements of the NRHM is the VHSNC. It is formed at the level of the revenue village. The formation of the VHSNC is a participatory process and the NRHM envisages the VHSNC to be in charge of decentralized planning and monitoring at the village level. It provides an institutional mechanism for the community to be informed of health programs and government initiatives and to participate in the planning and implementation of these programs.

The VHSNCs are expected to take collective action on issues related to health and its social determinants at the village level. Limited studies on operational aspects of VHSNCs, their formation, functioning, and inadequate feedback from community has necessitated the study on functioning of VHSNCs. There is also a need to ascertain whether there is appropriate understanding among the members about their roles, responsibilities, preparedness, and capacities to prepare village health plan (VHP).

Objective

The objectives of the study were to assess the constitution of the VHSNCs, the activities undertaken by them, and the funding and utilization status of the VHSNCs.

Materials and Methods

It was a community-based cross-sectional study conducted in three community-development blocks (CDBs) viz. Boko-Bongaon, Hajo, and Sualkuchi, of Kamrup district (rural), Assam. The study was conducted from July 1 to October 31, 2015. Permission to conduct the study was obtained from the institutional ethical committee. The study population consists of the VHSNCs formed and operational in the study areas and the members of VHSNCs. The Panchayati Raj Institution (PRI) members who are active members of the VHSNCs were mainly considered for the study. Wherever the PRI member could not be contacted after two attempts, any other member who was available and giving consent to participate, other than a health functionary, was included. The respondents who were available during the study period, not acutely ill and gave consent to participate in the study after due explanation of the study objectives, were included in the study. The sampling technique was multistage sampling.

Sample Size and Sample Collection Technique

Before the initiation of the data collection, meeting with the District Program Manager (DPM) and Block Program Managerial Units in the respective blocks, along with health workers such as auxiliary nurse midwife (ANM), accredited social health activist (ASHA), anganwadi worker (AWW), and local community leaders, were conducted for the purpose of discussing the topic and to ask for cooperation to carry out the study. The purpose of the study was explained to all. All the study subjects were informed about all the elements of the study including procedure, confidentiality, informed consent, and so on. Out of the total 12 blocks in Kamrup district, 25%, that is, 3 blocks were selected randomly. These are Boko-Bongaon CDB, Hajo CDB, and Sualkuchi CDB. 50% of the subcenters under each of these blocks were included in the study sample, which correspond to 20, 15, and 4 subcenters in Boko, Hajo, and Sualkuchi block respectively, a total of 39 subcenters. Two villages from each of these subcenters were selected. The nearest and farthest villages from the subcenter were selected to maintain uniformity. So, a total of 78 villages (Boko $20 \times 2 = 40$, Hajo $15 \times 2 = 30$, Sualkuchi $4 \times 2 = 8$, $40 + 30 + 8 = 78$) were included. The VHSNCs formed and operating in those villages were assessed in our study, that is, 78 VHSNCs.

The data were collected by a pretested and predesigned semistructured schedule prepared based on the guideline issued by the Ministry of Health and Family Welfare (MoHFW), Govt. of India, in 2013[5]; compiled in Microsoft Office Excel; descriptive statistics were done for different study variables.

Results

There were total 78 VHSNCs included in the study from 3 selected blocks of Kamrup (rural) district. A majority of them (55.12%) had 11 or more members (Table 1). PRI member, ANM, ASHA, AWW, and medical officer were members in all of the committees. Gao-burha (village headman), teacher, and mohila samiti member were among the representatives from non-health functionary (Table 2).

Numbers of monthly meetings were not regular, only 16.67% of the VHSNCs conducted 10–12 meetings in 1 year (Figure 1). The participation in the meetings was also not satisfactory as only in 33.34% meetings there were more than seven members present.

Maintaining of untied fund register updated and account details were important aspects of functioning of VHSNCs. It was observed in the study that, only 16.67% had maintained and updated the untied fund register (Table 3).

Table 1: Distribution of VHSNC according to the number of members in the committee.

Number of members	Frequency (*N* = 78)	Percentage
≤9	14	17.94
10	21	26.92
≥11	43	55.12
Total	78	100

Table 2: Distribution of VHSNC according to the composition of members

Type of member	*Frequency (*N* = 78)	*Percentage
PRI member	78	100
ANM	78	100
ASHA	78	100
AWW	78	100
ASHA supervisor	74	94.87
MPW	76	97.43
SHG member	49	62.82
Teacher	70	87.74
Gao-burha	72	92.30
Social worker	51	65.38
Mohila samiti member	66	84.61
Mothers group member	12	15.38
Medical officer	78	100

*Multiple responses.

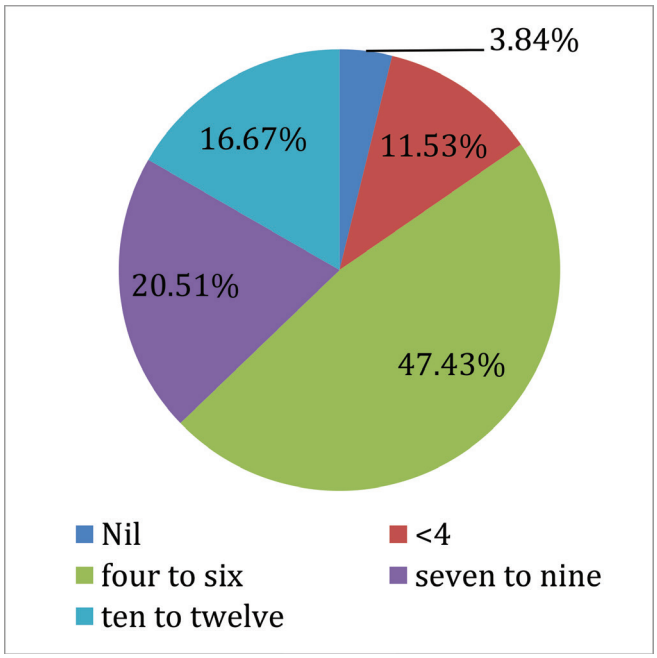

Figure 1: Distribution of VHSNC according to the number of meetings held during the last one year

Table 3: Distribution of VHSNC according to the maintenance of untied fund register and account details

	Status	Frequency	Percentage
Untied fund register and account details (*N* = 78)	Not maintained	7	8.97
	Maintained but not updated	58	74.35
	Maintained and updated	13	16.67
	Total	78	100

The researcher attended the meetings held during the study period and also interviewed the members regarding the issues discussed. Formation of new committee and new members (96.15%), ASHA's incentive (94.87%), and AWC repairing (88.76%) was some of the commonly discussed topic (Figure 2).

It was also observed that the untied fund to the VHSNCs, for a given financial year, was issued in the latter half of the year, for which many payments and disbursements could not be done in time and several expenses had to be made in credit. A majority 67.93% VHSNCs utilized more than 90% of the funds allotted to them (Table 4). Among the activities undertaken, AWC/SC development (79.48%), aiding pregnant women (57.69%), and providing sanitary latrine for BPL family (35.89%) were noted (Table 5).

Preparation of VHP is one of the very important responsibilities of VHSNC. It was observed in the study that the involvement of PRI member in VHP was very poor; ANM was associated alone in 20.50%, ANM with ASHA in 15.38%, whereas in 24.35% no VHP was prepared (Figure 3).

Discussion

VHSNC provides a platform for the people in the village level to participate in the health planning. For the decentralization process to establish properly and to be able to address peoples' needs, it has to abide by some minimum standards

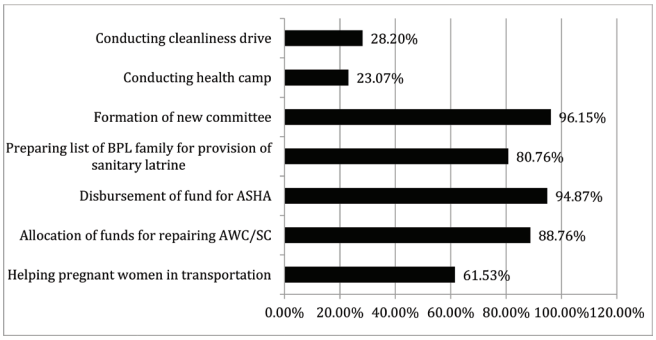

Figure 2: Distribution of VHSNC according to the major issues discussed in the meetings*

*Multiple responses.

Table 4: Distribution of VHSNC according to the proportion of expenditure of untied fund

Expenditure of Untied fund	Frequency (*N* = 78)	Percentage
<85%	14	17.94
85–90%	11	14.10
90–95%	29	37.17
>95%	24	30.76
TOTAL	78	100

Table 5: Distribution of VHSNC according to the major activities undertaken during the last one year

Activities undertaken	*Frequency (N = 78)	*Percentage
Sanitary latrine for BPL family	28	35.89
Aid for pregnant women	45	57.69
IEC activity	29	37.17
AWC/SC development	62	79.48
Conducting health camp	14	17.94
Others	7	8.97

*Multiple responses.

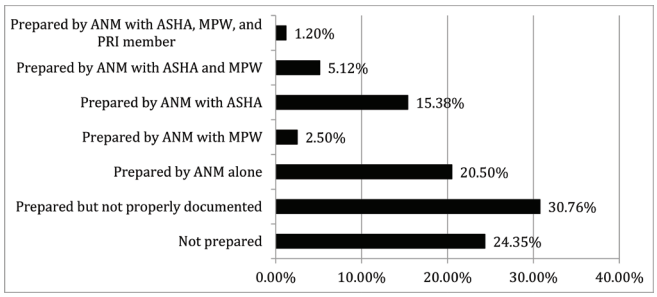

Figure 3: Distribution of VHSNC according to preparation of VHP and functionaries involved in it

laid down by the MoHFW, government of India guidelines published in 2013. In this study, we have tried to examine whether the VHSNC in the study area has been constituted and functioning according to the aforementioned guideline and compared the results with studies from other sources.

In our study, it was observed that, only 55.12% of the committees have 11 or more members, whereas, according to the guideline, VHSNC should have a minimum of 15 members. In an assessment of VHSNC in Chattisgarh,[6] it was observed that, most of the sample VHSCNCs (92%) had 6–15 members; 6–10 members in 41% VHSNCs and 11–15 members in 51% VHSNCs.

In our study, it was observed that, PRI member, ANM, ASHA, AWW, and MO were members in all of the committees; Gao-burha(village headman), teacher, mohila samiti member were among the representatives from non-health functionary. In an appraisal of functioning of VHSC in Orissa,[7] it has been observed that out of 20 VHSCs, all committees are represented by the ASHAs and SHG member (100%) of the village; AWW is a member in 95%; 90% VHSNCs are found to have ward members in their committees. Most of the committees have adolescent girls (70%). 60% committees have the ANMs and 50% have teachers as members. About 30% committees have members from village youth clubs and 20% VHSCs have sarpanch in their committee.

In our study, it was observed that, majority of the committees (47.43%) conducted 4-6 meetings in the last 1 year. 16.67% of the committees had 10-12 meetings, while 3.84% did not conduct any meeting in last 1 year. According to the new guidelines for VHSNC[5] issued by govt. of India in 2013, meetings of VHSNC should be held at least once every month. In a study done by the RRC-NE,[8] it was revealed that in Manipur, 64.57% VHSNCs have conducted 6 meetings in last 6 months, 13.57% have conducted 5 meetings in last 6 months, while 6.43% have conducted 4 meetings in last 6 months. However, 15.71% VHSNCs have never conducted any meeting in last 6 months, and these VHSNCs belong to Chandel district. In Meghalaya state, it was found that none of the VHSNCs have conducted five or six meetings in last 6 months. Maximum of the VHSNCs, that is, 37.75% VHSNCs have conducted only two meetings, followed by 18.26% VHSNCs having conducted only one meeting in last 6 months.

In our study, it was observed that, 16.67% of the committees have maintained duly updated untied fund registers with account details, while 74.35% of the committees have not updated the account details and 8.97% did not have proper untied fund register. In an assessment of VHSNC in Chattisgarh,[6] it was observed that 37% of the committees have maintained updated untied fund register.

In our study, it was observed that formation of new committee and new members (96.15%), ASHA's incentive (94.87%), and AWC repairing (88.76%) were some of the commonly discussed topics. In an assessment of the VHSNC in Rajasthan,[9] it was observed that commonly discussed topics during the monthly meetings were women and child development (87%), health awareness campaign (88%), and girl child development (76%).

In our study, it was observed that, a majority of (67.93%) VHSNCs utilized more than 90% of the funds allotted to them. In an analysis of NRHM in Madhya Pradesh,[10] they mentioned that, as per the guideline, all the VHSNCs received 10,000/- rupees per year and the money transferred is considered to be money utilized because the VHSNCs are not expected to submit any utilization certificate. In Mandla, 18% of the allotted fund was utilized by the committees in year 2009–10 and 69% of the fund were being utilized in 2010–11.

In our study, it was observed that, AWC/SC development, like buying furniture and water filter, repairing hand-pump, and so on were done by 79.48% of the VHSNCs; helping pregnant women for transportation was done by 57.69% VHSNCs. In an initiative of capacity building of VHSC, in Gujrat,[11] it was observed that, purchase of materials for VHND was done by 49% VHSNCs, bed-net medicating solution bought by 13%, cleanliness campaign, chlorination of wells, and so on were

done by 14%, and health awareness program in the village was done by 7% of the VHSNCs.

It was observed in our study that involvement of PRI member in VHP was very poor; ANM was associated alone in 20.50% and ANM with ASHA in 15.38%, whereas in 24.35% no VHP was prepared. In a rapid appraisal of NRHM in Jalgaon, Maharashtra,[12] it was seen that most of the Gram Panchayats have reported the existence of the VHSNC in their village and far less (29%) reported the preparation of the VHP.

Strengths of the Study

Primary health care approach emphasizes on community participation in understanding the health needs of the community, and VHSNC is formed to address that. VHSNCs' optimum functioning depends on the active leadership role assumed by the people's representatives at the grassroots level. The internal program implementation review mechanism has highlighted the lack of clarity over roles and responsibilities of VHSNCs and has necessitated these types of studies. Through our study, some important aspects of the VHSNC have been highlighted, and hopefully this attempt will inspire other researchers to focus on this topic too.

Limitations of the Study

First, the present study was conducted in the Boko, Hajo, and Sualkuchi block of Karup district. The study area shows a wide diversity in geographical distribution, which restricted the accessibility to various regions. Therefore, representations from some regions could not be included in the study, which may restrict the generalizability of results. Second, for assessing the VHSNCs, the Block Program Managers were contacted and the functionaries such as ANM, ASHA, and AWW were preinformed about the purpose and objectives of the study. This prior information regarding the researcher's visit among the functionaries may limit the visualization of the actual scenario in the VHSNCs.

Conclusion

The present study on the assessment of the functioning of the VHSNC in rural areas of Kamrup district, Assam, was conducted with the objectives of ascertaining the constitution, activities, and fund utilization status of the VHSNCs. It was observed that although VHSNCs have been constituted in all of the revenue villages in the study area, there are several lacunae in their organization. Out of the total 78 VHSNCs, only about half (55.12%) of the committees had more than 11 members, and majority (47.43%) of the committees held only 4–6 meetings in 1 year. Regarding maintenance of untied fund register, it was not updated in 74.35% VHSNCs. Majority of the VHSNCs (67.93%) have utilized >90% of the untied fund; AWC/SC development (79.48%) and helping poor patients (57.69%) were the major activities. It was observed that about one-fourth (24.35%) of the committees have not prepared VHP.

A properly coordinated and regularly supervised and monitoring system along with strict accountability mechanism should help in improving the current scenario of the VHSNCs. Periodic sensitization of their duties and encouragement of the functionaries involved, regarding performances, can motivate them.

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